Patient Safety
WellSpan Health

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WellSpan demographics

- 2 hospitals- total 550 beds
- Home care –90,000 visits
- 6 Ambulatory Pharmacies – 370,000 prescriptions
- 39 physician offices – 400,000 visits
- 6000 employees
- 800 physicians

WellSpan Health Patient Safety Principles

- Patient Safety is a strategic priority for WellSpan Health.
- We facilitate the reporting and management of errors.
- We're committed to patient disclosure.
- We proactively manage errors.
- We make patient safety everyone's responsibility.
- We strive to ensure safe environments.
- We support team-based care.

Approach in 2002

- ALL WellSpan entities have Patient Safety Committee
  - WellSpan Health Committee – Oversight
    - Since 1999
  - 3 **required** Act l3 (hospitals and outpatient surgery facility) community members involved
  - 3 **not** required – Ambulatory Pharmacy, Home Health, Physician offices

Patient Safety Plans say…..

- Education of all staff (new, existing, medical staff)
  - Show Beyond Blame video
  - Required education staff
  - Medical staff – mailed information and presented at committees
- Assess attitudes of employees on safety
- Promote teamwork, mutual respect and enhanced communication among staff
- Conduct audits on best practices – JCAHO, AHRQ, NQF, ISMP, etc.
- Ongoing education on adverse event reporting – Dr. Quality
- Staff performance plans and evaluations

Many questions on disclosure and reporting

- Developed internal algorithm--when to report and when not to report
- Disclosure policy
- "Disclosure of unanticipated events"

  American Risk Management Association
- Chapter 51 reporting

CURRENT WELLSPAN ACT 13 INTERPRETATION:
TO REPORT OR NOT TO REPORT ?

Was this event:

Natural result of the patient's underlying condition (if event of omission or commission Occurred, but underlying condition could also be the cause, is there even a small chance [</= 5 %] that the condition was the proximal cause of proposed patient injury), YES ? do not report

NO **?**

Complications of treatment which occur with predictable regularity (e.g.: bowel nicks during lysis of adhesions, restenosis of angioplasties) and the patient has been told of these type complications prior to performance of the procedure or service (not complications of a severity not regularly expected) YES ? do not report

NO **?**

Ancillary procedures performed according to the standard of care with complications that occur with predictable regularity and are covered by the patient's general admission consent (e.g.: IV infiltration, mild catheter related infection). YES ? do not report

NO **?**

Is there:

1. Harm to physical health, function or appearance (not just 'pain') NO ? Go to # 3.

YES **?**

2. Need for more than first aid type additional treatment, YES ? evaluate for report

NO **?**

3. Medication event with any harm or requiring any additional treatment (even 'first aid'), except allergic reactions with no history of allergy to that class of medications. YES ? evaluate for report

NO **?**

4. Need for additional laboratory or radiological type testing [does not include a single routine blood test (i.e.: CBC, electrolytes, glucometer, etc) or plain x-ray as the only additional testing] YES ? evaluate for report

NO **?**

5. Need for invasive monitoring, or longer hospitalization by one or more days or transfer to an intensive care or other unit for additional monitoring YES ? evaluate for report

NO **?**

6. Obvious and indisputable failure to recognize or be provided with an abnormal test or finding, or provide an ordered treatment, and therefore deliver appropriate treatment, with one of the results described above. YES ? evaluate for report

NO **?**

Do not report

Internal Reporting real time

- Over 8000 events have been entered (Falls, Medication/Infusion, Adverse Clinical, Administrative events)
  - Level of Impact 0-10
  - Automatic e-mail notification

Best Practices

- Executive safety walkarounds –
  - Security system in Pediatrics, grab bars in L&D bathrooms, adjustment in ventilation system, improved patient identification process ambulance crews transporting patients. Etc. etc. etc.etc.etc.
- Barcoding POC glucose monitoring
- Triggers – stories/lessons learned
- Safeguards – computer screens
- Patient Brochure
- Therapeutic Guide 2003 edition

JCAHO

- Assessed compliance to JCAHO 6 goals
  - Abbreviation list – disagree short list
  - 9 Medication prescribing standards
- Review Sentinel Event Alerts (29)
- "Time Out" – surgical site identification
- "Write down and read back" – verbal orders

Executive Patient Safety dashboard (work in progress)

Patient Falls Hospitals (2) Home Care	Leapfrog – **CABG 450** **Coronary angioplasty 400** **AAA repair 50** **Esophagectomy 13** **Pancreatic resection 11** **NICU (average daily census>15**	ICU indicators Ventilator Bundle – HOD, PUD, DVT, weaning, glucose ICU LOS and Mortality rate
Medication errors --Total --Reaching patient --Causing harm	Clean Surgical Site Infection rate	Adding: more this year!

AHRQ patient safety practices and targets

- ***Adverse Drug Events***
- Clinical pharmacists role
- Protocols in High-Risk Drugs
- Unit-dose drug distribution
- Automated Medication Dispensing Devices

- ***Infection Control***
- Hand washing compliance
- HOB – Vent patients Prevention of VAP
- ***Organization, Structure ad Culture***
- ICU model – critical care specialists

Challenges this year

- Getting started:
  - Patient Safety officers role?
  - Patient Safety Committee agendas?
  - Number of employees educated
  - Disclosure skills – personal fear
    - `Times change quickly, but Humans don't` - (RM, Legal, QM, nurses, physicians)
  - Upfront Patient Safety costs

Patient Safety Culture

- Working on……
- RCA & HFMEA guidelines – 10 trained facilitators
- "Beyond Blame" & "Do Know Harm" video
- RCA Teams (every Act l3) like the non-punitive meetings and sharing
- Required employee education
- Reporting to Boards, PI, Medication Safety Committees
- Constantly working ……..

References

- "Monograph – Disclosure of unanticipated events: the next step in better communication with patients" May, 2003 American Society for Healthcare Risk Management of the AHA
- "Creating a Culture of Safety – Preliminary Guide to the Patient Safety Provisions of Act l3 of 2002" – Pennsylvania Medical Society and Hospital and HealthSystem Association of Penna.
- "The Business Case for Patient Safety and Clinical Quality" – VHA
- 5th Annual NPSF Patient Safety Congress – March 12-15 2003 Washington, D.C.